



Utilization Management Policy

Date Extensions

Table of Contents

Policy Statement.....	1
Purpose.....	1
Scope.....	1
References.....	2
History.....	2

Related Policies

[Timeframe of UM Decisions and Notifications](#)
[Utilization Management Overview](#)

Policy Number

368

Original Effective Date: 9/2002
Current Approval Date: 4/23/20
Next Review: 4/2021
Category: Administrative

Policy Statement

Up to one requested date extension may be approved for an episode of care with the following provisions:

1. The health care provider anticipates that the patient will be discharged during the extended period of the treatment plan.
2. The health care provider requires only an additional duration of treatment and not services in addition to those currently approved or targeted.
3. The date extension is requested within 30 days of the end date of the treatment period for which it is being requested.
4. The date extension does not create an overlap with the treatment period on a subsequent submission.
5. Date extensions of treatment plans for pediatric patients that extend the treatment period to beyond thirty (30) days must be clinically approved

Purpose

To allow for up to a two week period of care beyond the currently approved duration of treatment without requiring the submission of a new Patient Summary Form.

Scope

All in network health care providers, involving all provider types, where the submission of clinical information is a requirement. This policy is subject to Health Plan Client and state regulatory requirements.



Utilization Management Policy

References

1. Consensus – Utilization Management Committee
2. National Committee for Quality Assurance (NCQA). <http://www.ncqa.org/>

Policy History/Revision Information

Date	Action/Description
9/20/2002	Original effective date
11/11/2003	Annual review and approval completed
10/18/2004	Annual review and approval completed
2/14/2006	Annual review and approval completed
4/10/2008	Annual review and approval completed
1/15/2009	Policy reformatted
4/30/2009	Annual review and approval completed
4/08/2010	Annual review and approval completed; Scope updated to describe the policy's subordination to health plan requirements; References updated
10/26/2010	Policy rebranded to "OptumHealth Care Solutions, Inc. (OptumHealth)"
4/07/2011	Annual review and approval completed
4/19/2012	Annual review and approval completed
4/18/2013	Annual review and approval completed
4/17/2014	Annual review and approval completed; Policy rebranded "Optum* by OptumHealth Care Solutions, Inc."
4/16/2015	Annual review and approval completed
4/21/2016	Updated references; Annual review and approval completed
4/20/2017	Updated references; Annual review and approval completed; Legal entity name changed from "OptumHealth Care Solutions, Inc." to "OptumHealth Care Solutions, LLC."
4/26/2018	Annual review and approval completed
4/25/2019	Annual review and approval completed
4/23/2020	Annual review and approval completed; no significant changes made to the document

Contact Information

Please forward any commentary or feedback on Optum utilization management policies to: policy.inquiry@optumhealth.com with the word "Policy" in the subject line.

The services described in Optum* by OptumHealth Care Solutions, LLC policies are subject to the terms, conditions and limitations of the Member's contract or certificate. Optum reserves the right, in its sole discretion, to modify policies as necessary without prior written notice unless otherwise required by Optum's administrative procedures.

Certain internal policies may not be applicable to self-funded members and certain insured products. Refer to the member's Summary Plan Description (SPD) or Certificate of Coverage (COC) to determine whether coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies. If there is a difference between any policy and the member's SPD or COC, the member's SPD or COC will govern.

*Optum is a brand used by OptumHealth Care Solutions, LLC and its affiliates